DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #03-32

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 2, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $6,900,000
b. FFY 2005 $6,900,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Pages 29, 30, 31 & 32

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Pages 29, 30, 31 & 32

10. SUBJECT OF AMENDMENT:
Outpatient DSH

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Janet Schalansky – signature//

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary of Social & Rehabilitation Services

15. DATE SUBMITTED:
December 23, 2003

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
DEC 23 2003

18. DATE APPROVED:
June 28, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN - 2 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Theresa A Smith

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Per verbal change to block #19, shall be Jan. 2, 2004

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

An example of both the eligibility and payment adjustment computations are attached.

6.3000 Simultaneous Option 1 and Option 2 Eligibility

If a hospital is eligible under both 6.1000 and 6.2000 the disproportionate share payment adjustment shall be the greater of these two options.

6.4000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000 or 6.2000, a hospital may request in writing a review of the determination within 30 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

6.5000 Payment Limitations

If the payments determined exceed the allotment determined by CMS in accordance with section 1923(f) (1) (C) of the Social Security Act, then all hospitals eligible for disproportionate share shall have their disproportionate share payments reduced by an equivalent percentage which will result in an aggregate payment equal to the allotment determined by CMS.

All hospitals are limited to no more than the Kansas Medicaid inpatient portion of 100% of the cost of the uninsured plus the difference between the cost of the Kansas Medicaid inpatient and outpatient services and the payments for Kansas Medicaid inpatient and outpatient services. Data for both the uninsured and Medicaid cost and payments shall be based upon the Medicare cost report which must be available as of the start of the state fiscal year for which payments are to be made. The Kansas Medicaid inpatient portion is the ratio of Kansas Medicaid/MediKan inpatient days divided by total Medicaid/MediKan inpatient days. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

During State Fiscal Year 2004 and 2005, the limitation on payment for Disproportionate Share (DSH) for Public Hospitals is changed from the total of 100% of the cost of the uninsured plus the loss on Medicaid inpatient services to 175% of the cost of the uninsured. There is no change in the limitation for either State or non Public hospitals. This change also applied to Section D2 thru D4 of the attached form.

The allotment limitation will be evaluated in the following sequence. First only the amount of DSH considering the cost of the uninsured plus the difference between the cost of the Kansas Medicaid inpatient services and the payments for Kansas Medicaid inpatient services shall be considered. If this amount exceeds the allotment, then neither the outpatient services or the 175% of the cost of the uninsured shall be considered. If this does not exceed the allotment, then the difference between the cost of the Kansas Medicaid outpatient services and the payments for Kansas Medicaid outpatient services shall be considered in addition to the first step. If this amount exceeds the allotment, then the 175% of the cost of the uninsured shall not be considered. If this amount does not exceed the allotment, then the 175% of the cost of the uninsured shall be considered.

Disproportionate Share Low-Income Utilization

All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory sugical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar references.

Hospital Name _____

Kansas Medicaid Number _____ **Fiscal Year Ending** _____

A1 **Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payemnts. Contact Health Care Policy (785-296-3981) for a log summary.** _____

A1a **Medicaid/MediKan outpatient payments for the most recent available hospital fiscal year. Outpatient payments only includes payments made to the hospital for outpatient services.** _____

Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))

A2 _____

A3 **Total Medicaid/Medikan, State and local government funds. (A1 + A1a + A2)** _____

A4 **Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8)-other appropriate lines)** _____

A5 **Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3)** _____

A6 **Ratio of inpatient revenues to total patient revenues (A4) A5)** _____

A7 **Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2)** _____

A8 **Inpatient share of contractual allowances and discounts (A6 H A7)** _____

A9 **Net inpatient revenue (A4 - A8)** _____

A10 **Ratio of Medicaid/Medikan, State and local government funds to net inpatient revenue (A3) A9)** _____

B1 **Inpatient charity care charges. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spendown incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review.** _____

B1a **Outpatient charity care charges. Outpatient services only includes services provided by the hospital and reported in the Medicare cost report as outpatient services. All other requirements in B1 apply here.** _____

B2 **Other State and local government funds (A2)** _____

B3	Ratio of inpatient revenues to total patient revenues (A6)	
B4	Inpatient portion of State and local government funds (B2 H B3)	
B5	Hospital costs (Medicare Worksheet B Part I, Total Column, Subtotal (Line 95) - SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Rural Health Clinic (Line 63) - Ambulance (Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93))	
B6 -	Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) SNF (Line 6) - ICF (Line 7) - LTCU(Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC(Line 22) - Hospice (Line 23))	
B7	Cost to revenue ratio (B5) B6)	
B8	Hospital revenue attributable to the inpatient portion of State and local government funds (B4) B7)	
B9	Unduplicated charity care charges (B1 + B1a - B8 (if negative use 0))	
B10	Ratio of unduplicated charity care to total inpatient revenue (B9) A4)	
C1	Low-Income utilization rate (A10 + B10)	

Section D only applies if C1 exceeds 0.25 and there is a minimum 1% Medicaid utilization.

D1	Hospital Limitation. All hospital are limited to no more than 100% of their net Medicaid cost plus the cost of the uninsured for FY 2001. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. Report the uninsured here. Do not report Medicaid here. This line must be completed or no disproportionate share payments will be made.	
D2	Cost of the uninsured (D1 x B7)	
D3	Loss (gain) on Inpatient Kansas Medicaid payments (Computed by Medicaid)	
D3a	Loss (gain) on Outpatient Kansas Medicaid Payments (Computed by Medicaid)	
D4	Subtotal of eligible losses (D2+D3+D3a)	
D5	Kansas Medicaid Inpatient Days in last available fiscal year of hospital	
D6	All Medicaid Inpatient Days in last available fiscal year of hospital	
D7	Kansas portion of Medicaid inpatient days (D5) D6)	
D8	Estimated Disproportionate Share Payments (D7 x D4)	

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.

Signature of Officer/Administrator

Title

Date

D2	Cost of the uninsured (D1 X B7)	
D3	Loss on Inpatient Kansas Medicaid payments (Computed by Medicaid)	
D4	Subtotal of eligible losses (D2 + D3)	
D5	Kansas Medicaid Inpatient Days in last available fiscal year of hospital	
D6	All Medicaid Inpatient Days in last available fiscal year of hospital	
D7	Kansas portion of Medicaid inpatients days (D5 ÷ D6)	
D8	Estimated Disproportionate Share Payments (D7 X D4)	

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.

Signature of Officer/Administrator

Title

Date